

		FOR OHF USE					

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**2001**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2001)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0040584</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Baptist Retirement Home</u>		<b>I have examined the contents of the accompanying report to the</b> <b>State of Illinois, for the period from</b> <u>9/1/00</u> <b>to</b> <u>8/31/01</u> <b>and certify to the best of my knowledge and belief that the said contents</b> <b>are true, accurate and complete statements in accordance with</b> <b>applicable instructions. Declaration of preparer (other than provider)</b> <b>is based on all information of which preparer has any knowledge.</b>	
<b>Address:</b> <u>316 Randolph</u> <u>Maywood</u> <u>60153</u> <div style="display: flex; justify-content: space-between;"> <span>Number</span> <span>City</span> <span>Zip Code</span> </div>		<b>Intentional misrepresentation or falsification of any information</b> <b>in this cost report may be punishable by fine and/or imprisonment.</b>	
<b>County:</b> <u>Cook</u>		<b>Officer or Administrator of Provider</b>	
<b>Telephone Number:</b> <u>(708) 344-1541</u> <b>Fax # ( )</b>		(Signed) _____ (Date) _____	
<b>IDPA ID Number:</b> <u>36-2166967001</u>		(Type or Print Name) <u>Mike Warden</u>	
<b>Date of Initial License for Current Owners:</b> <u>10/18/60</u>		(Title) <u>Vice President of Finance</u>	
<b>Type of Ownership:</b>		(Signed) _____ (Date) _____	
<input checked="" type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b>		<b>Paid Preparer</b>	
<input type="checkbox"/> <b>PROPRIETARY</b>		(Print Name and Title) _____	
<input type="checkbox"/> <b>GOVERNMENTAL</b>		(Firm Name & Address) _____	
<input checked="" type="checkbox"/> Charitable Corp.		(Telephone) <u>( )</u> <b>Fax # ( )</b>	
<input type="checkbox"/> Trust		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b>	
<b>IRS Exemption Code</b> <u>"501C3"</u>		<b>Phone # (217) 782-1630</b>	
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Deb Kotcher</u> <b>Telephone Number:</b> <u>(952-) 253-1485</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Baptist Retirement Home# 0040584 Report Period Beginning: 9/1/00 Ending: 8/31/01

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	75	Intermediate (ICF)	75	27,375	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	75	TOTALS	75	27,375	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	11,098	12,279		23,377	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,098	12,279		23,377	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 85.40%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 10/8/60

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date \_\_\_\_\_ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number  
of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 8/31/2000 Fiscal Year: 8/31/2000

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number      Baptist Retirement Home      #      0040584      Report Period Beginning:      9/1/00      Ending:      8/31/01

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	243,464	15,746	119,105	378,315	(168,417)	209,898	(143,172)	66,726		1
2	Food Purchase		213,189		213,189	167,938	381,127	(143,172)	237,955		2
3	Housekeeping	157,782	10,999		168,781	(1,793)	166,988	(54,555)	112,433		3
4	Laundry	8,573	2,999	124	11,696	1,793	13,489	(4,407)	9,082		4
5	Heat and Other Utilities			190,807	190,807	2,219	193,026	(63,062)	129,964		5
6	Maintenance	46,185	10,200	155,224	211,609	1,073	212,682	(69,483)	143,199		6
7	Other (specify):*			9,025	9,025	5,074	14,099	(4,606)	9,493		7
8	<b>TOTAL General Services</b>	456,004	253,133	474,285	1,183,422	7,887	1,191,309	(482,457)	708,852		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			11,700	11,700		11,700		11,700		9
10	Nursing and Medical Records	759,930	36,184	426,945	1,223,059	2,543	1,225,602	(19,010)	1,206,592		10
10a	Therapy										10a
11	Activities	34,208	5,354	1,970	41,532		41,532	(30)	41,502		11
12	Social Services			10,101	10,101		10,101		10,101		12
13	Nurse Aide Training										13
14	Program Transportation			333	333		333		333		14
15	Other (specify):*	39,326	140	323	39,789		39,789		39,789		15
16	<b>TOTAL Health Care and Programs</b>	833,464	41,678	451,372	1,326,514	2,543	1,329,057	(19,040)	1,310,017		16
	<b>C. General Administration</b>										
17	Administrative	88,895	3,598	164,760	257,253	(37,892)	219,361	55,423	274,784		17
18	Directors Fees										18
19	Professional Services			1,595	1,595		1,595		1,595		19
20	Dues, Fees, Subscriptions & Promotions			26,612	26,612	205	26,817	1,200	28,017		20
21	Clerical & General Office Expenses	70,097	4,908	11,314	86,319		86,319	(24,661)	61,658		21
22	Employee Benefits & Payroll Taxes			210,517	210,517	15,278	225,795	(18,914)	206,881		22
23	Inservice Training & Education			1,093	1,093		1,093		1,093		23
24	Travel and Seminar			2,928	2,928		2,928		2,928		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			30,961	30,961		30,961	(10,115)	20,846		26
27	Other (specify):*			64,236	64,236	10,913	75,149		75,149		27
28	<b>TOTAL General Administration</b>	158,992	8,506	514,016	681,514	(11,496)	670,018	2,933	672,951		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,448,460	303,317	1,439,673	3,191,450	(1,066)	3,190,384	(498,564)	2,691,820		29

\* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name &amp; ID Number

Baptist Retirement Home

#0040584

Report Period Beginning:

9/1/00

Ending:

8/31/01

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			144,424	144,424	14,868	159,292	839	160,131			30
31	Amortization of Pre-Op. & Org.			4,037	4,037		4,037		4,037			31
32	Interest			90,552	90,552	(13,802)	76,750	(36,519)	40,231			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			239,013	239,013	1,066	240,079	(35,680)	204,399			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,063	41,063		41,063		41,063			42
43	Other (specify):*			927	927		927		927			43
44	<b>TOTAL Special Cost Centers</b>			41,990	41,990		41,990		41,990			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,448,460	303,317	1,720,676	3,472,453		3,472,453	(534,244)	2,938,209			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Baptist Retirement Home

# 0040584

Report Period Beginning:

9/1/00

Ending:

8/31/01

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,356)			4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	18,622			7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	839			9
10	Interest and Other Investment Income	(36,519)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(66)			15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	3,605			17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(607,994)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (624,869)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	90,626		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 90,626		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (534,243)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

**Baptist Retirement Home**

ID# 0040584

Report Period Beginning: 9/1/00

Ending: 8/31/01

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Guest Meals	\$ (1,678)	1	1
2	Guest Meals	(1,678)	2	2
3	Activities Revenue	(30)	11	3
4	Straight Line Depreciation	839	30	4
5	Incontinent Care	(17,810)	10	5
6	Rental Income	36,462	17	6
7	Interest Income	(36,519)	32	7
8	Late Payment	3,605	21	8
9	Transportation	(66)	21	9
10	Related Organization	90,626	17	10
11	Nursing Supplies	(1,200)	10	11
12	Nursing Supplies	1,200	20	12
13	Independent Living Offset	(607,994)		13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(534,243)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Baptist Retirement Home# 0040584

Report Period Beginning:

9/1/00

Ending:

8/31/01

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	(1,678)	0	0	0	0	0	0	0	0	0	0	(1,678)	1
2	Food Purchase	(1,678)	0	0	0	0	0	0	0	0	0	0	(1,678)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(3,356)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(3,356)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(19,010)	0	0	0	0	0	0	0	0	0	0	(19,010)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(30)	0	0	0	0	0	0	0	0	0	0	(30)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(19,040)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(19,040)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	127,088	0	0	0	0	0	0	0	0	0	0	127,088	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	1,200	0	0	0	0	0	0	0	0	0	0	1,200	20
21	Clerical & General Office Expenses	3,539	0	0	0	0	0	0	0	0	0	0	3,539	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>131,827</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>131,827</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>109,431</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>109,431</b>	<b>29</b>

## Summary B

8/31/01

[illegible]



Facility Name & ID Number **Baptist Retirement Home**# **0040584**

Report Period Beginning:

9/1/00

Ending:

8/31/01

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	Management Fee	\$ 164,760	American Baptist Homes of the Midwest	100.00%	\$ 255,386	\$ 90,626	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 164,760			\$ 255,386	\$ * 90,626	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Baptist Retirement Home # 0040584 Report Period Beginning: 9/1/00 Ending: 8/31/01

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This is not Applicable								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Baptist Retirement Home# 0040584

Report Period Beginning:

9/1/00

Ending:

8/31/01

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Management Fee	Days	488,716	18	\$ 3,423,420	\$ 1,877,084	36,458	\$ 255,386
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25	TOTALS					\$ 3,423,420	\$ 1,877,084		\$ 255,386

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Banco Polular		X	Refinance Renovation	Yes	11/20/1995	\$ 1,600,000	\$ 1,319,766	11/20/2015	6.1300	\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 1,600,000	\$ 1,319,766			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,600,000	\$ 1,319,766			\$	15	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Baptist Retirement Home**# **0040584**

Report Period Beginning:

**9/1/00**

Ending:

**8/31/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2000 report.			\$ <b>NA</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$ <b>#VALUE!</b>	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ <b>#VALUE!</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1996	8		
	1997	9		
	1998	10		
	1999	11		
	2000	12		
			<b>FOR OHF USE ONLY</b>	
			13	FROM R. E. TAX STATEMENT FOR 2000 \$ 13
			14	PLUS APPEAL COST FROM LINE 5 \$ 14
			15	LESS REFUND FROM LINE 6 \$ 15
			16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Baptist Retirement Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040584

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE (     ) \_\_\_\_\_ FAX #: (     ) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	<b>\$ _____</b>	<b>\$ _____</b>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:
 

24,791

B. General Construction Type:
 Exterior
 

Brick

 Frame
 

Steel

 Number of Stories
 

1

C. Does the Operating Entity?
 

X

 (a) Own the Facility
 
 (b) Rent from a Related Organization.
 
 (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 

X

 (a) Own the Equipment
 
 (b) Rent equipment from a Related Organization.
 
 (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 
 YES
 

X

 NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
 
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1965	\$ 31,966	1
2					2
3	TOTALS			\$ 31,966	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Baptist Retirement Home

# 0040584

Report Period Beginning:

9/1/00

Ending:

8/31/01

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	75		1973	1973	\$ 238,941	\$ 4,799	50	\$ 4,799	\$	\$ 135,949	4
5			1965	1965	233,438	4,669	50	4,669		170,135	5
6			1996	1996	495,474	59,785	25	59,785		139,061	6
7											7
8											8
	<b>Improvement Type**</b>										
9	Hand Rails		1978		938	19	50	19		440	9
10	Sprinkler System		1982		76,614	1,532	50	1,532		29,772	10
11	Lighting, Roof, Cabinets		1995		2,868		15			2,868	11
12	Air Cond, Fire Damper		1986		20,587	967	15	967		20,587	12
13	Roof Reconstruction		1987		4,715	314	15	314		4,534	13
14	Auto Door System		1992		2,516	168	15	168		1,581	14
15	Remodeling		1993		11,770	785	15	785		6,609	15
16	Roof		1997		36,400	1,820	20	1,820		15,328	16
17	Chair Lift		1993		3,427	228	15	228		1,923	17
18	First Floor Remodel		1993		28,045	1,402	20	1,402		11,809	18
19	Front Doors		1993		9,265	927	10	927		7,804	19
20	Carpeting		1993		3,824	382	10	382		3,219	20
21	Tub Refinishing		1993		260		5			260	21
22	Roof Replacement		1994		35,600	1,780	20	1,780		13,211	22
23	Driveway		1994		2,780		5			2,780	23
24	Carpeting		1994		696	70	10	70		518	24
25	Tuckpointing		1994		450		5			450	25
26	Kitchen Sink		1994		1,758	176	10	176		1,305	26
27	Boiler Repairs		1994		14,307	1,431	10	1,431		10,619	27
28	New Boiler		1994		12,900	1,290	10	1,290		8,818	28
29	Roof Repair		1994		23,300	1,165	20	1,165		7,963	29
30	New Boiler		1995		33,850	3,385	10	3,385		22,285	30
31	Land Improvements Acq		1995		3,250	163	20	163		1,139	31
32	Tank Removal		1995		6,094	305	20	305		2,134	32
33	Tank Removal Fill		1995		1,198	60	20	60		420	33
34	Final/Retainage		1996		36,303	3,025	12	3,025		14,810	34
35	Architectural Services		1996		10,697	891	12	891		4,356	35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT



**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	4 Trees	1996	\$ 1,500	\$ 75	20	\$ 75		\$ 375		37
38	Landscaping	1996	375	18	20	18		93		38
39	Various Improvements	1996	2,844	284	10	284		1,399		39
40	Door Closers	1997	262	10	25	10		51		40
41	Windows 4th Floor	1997	13,164	527	25	527		2,107		41
42	Reception Desk	1997	2,462	98	25	98		393		42
43	Chapel Floor	1997	2,839	114	25	114		455		43
44	Carport	1998	6,730	337	20	337		1,347		44
45	Tile Floor Lobby	1998	6,500	260	25	260		780		45
46	Carpet, Ceiling	1998	14,285	571	25	571		1,713		46
47	Windows SW Wing	1998	9,944	398	25	398		1,194		47
48	Windows SW Wing	1998	11,226	449	25	449		1,347		48
49	Install Windows	1998	4,283	171	25	171		513		49
50	Concrete Sidewalks	1998	5,000	250	20	250		500		50
51	Chaplains Office	1998	6,984	349	20	349		698		51
52	Concrete Steps	1999	2,400	120	20	120		240		52
53	Roof Repair	1999	2,275	114	20	114		228		53
54	Roof Repair	1999	2,520	126	20	126		252		54
55	Lock Replacement	2000	874	44	20	44		88		55
56	Lock Repair	2000	132	7	20	7		14		56
57	Electrical Circuits	2000	2,470	124	20	124		248		57
58	Laundry Room Plumbing	2000	6,014	301	20	301		602		58
59	Cooling Tower	2000	11,039	552	20	552		1,104		59
60	Cooling Tower Plumbing	2000	14,283	714	20	714		1,428		60
61	Chemtech Pump	2000	1,034	52	20	52		104		61
62	Cooling Tower Work	2000	4,880	244	20	244		488		62
63	Install Pressure Valve on Boiler	2001	2,625	131	20	131	(131)			63
64	Commercial Steel Doors	2001	14,160	708	20	708	(708)			64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 1,505,369	\$ 98,685		\$ 98,685	\$ (839)	\$ 660,447		70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 793,188	\$ 84,639	\$ 84,639	\$ (0)	Various	\$ 315,591	71
72	Current Year Purchases	38,681						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 831,869	\$ 84,639	\$ 84,639	\$ (0)		\$ 315,591	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,369,204	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 183,324	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 183,324	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (839)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 976,038	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 2002 \$ \_\_\_\_\_

13. 2003 \$ \_\_\_\_\_

14. 2004 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
**SEE ACCOUNTANTS' COMPILATION REPORT**

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
	Licensed Speech and Language Development Therapist		hrs								2
2	Licensed Recreational Therapist		hrs								3
3	Licensed Physical Therapist		hrs								4
4	Physician Care		visits								5
5	Dental Care		visits								6
6	Work Related Program		hrs								7
7	Habilitation		hrs								8
8			# of prescrpts								9
9	Pharmacy										
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
10	Academic Education		hrs								11
11	Exceptional Care Program										12
12											
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 712,426	\$	1
2	Cash-Patient Deposits	(164)		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	210,701		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Debt Issue Costs	57,527		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 980,490	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	44,500		13
14	Buildings, at Historical Cost	1,506,852		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	831,870		16
17	Accumulated Depreciation (book methods)	(648,926)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Life Insurance	32,425		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,766,721	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,747,211	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 89,736	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	53,908		29
30	Accrued Salaries Payable	6,954		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Intercompany Account	4,512,652		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,663,250	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,265,858		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	39,826		42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,305,684	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 5,968,934	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (788,804)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,180,130	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(788,804)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (788,804)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (788,804)</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,658,612	1
2	Discounts and Allowances for all Levels	(60,185)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,598,427	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	4,445	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	5,094	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	3,062	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	75,062	18
19	Laboratory		19
20	Radiology and X-Ray	(868)	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 86,795	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	3,712	24
25	Interest and Other Investment Income***	(11,872)	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ (8,160)	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,677,062	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,217,890	31
32	Health Care	1,277,479	32
33	General Administration	664,535	33
<b>B. Capital Expense</b>			
34	Ownership	292,105	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	13,857	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,465,866	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(788,804)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (788,804)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. **SEE ACCOUNTANTS' COMPILATION REPORT**

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



Facility Name & ID Number **Baptist Retirement Home**# **0040584**Report Period Beginning: **9/1/00**Ending: **8/31/01****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	3,112	3,152	\$ 78,014	\$ 24.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	641	187	12,900	68.98	3
4	Licensed Practical Nurses	13,539	14,573	230,856	15.84	4
5	Nurse Aides & Orderlies	59,584	59,834	501,649	8.38	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,128	2,216	21,201	9.57	9
10	Activity Assistants	1,556	1,635	12,602	7.71	10
11	Social Service Workers	135	140	3,375	24.11	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	6,751	6,945	66,402	9.56	15
16	Dishwashers	14,310	14,915	99,991	6.70	16
17	Maintenance Workers	4,207	4,616	45,638	9.89	17
18	Housekeepers	21,624	23,146	162,867	7.04	18
19	Laundry	877	893	6,090	6.82	19
20	Administrator	2,064	2,169	84,814	39.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,356	2,516	26,982	10.72	23
24	Clerical	6,684	7,080	67,912	9.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Chaplain</u>	1,408	1,451	27,167	18.72	33
34	TOTAL (lines 1 - 33)	140,976	145,468	\$ 1,448,460 *	\$ 9.96	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	117	11,700	9.3	36
37	Medical Records Consultant	25	495	10.3	37
38	Nurse Consultant		83,616	10.3	38
39	Pharmacist Consultant	14	950	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	404	10,101	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	560	\$ 106,861		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	16	\$ 652	10.3	50
51	Licensed Practical Nurses	3,376	121,049	10.3	51
52	Nurse Aides	6,325	110,547	10.3	52
53	TOTAL (lines 50 - 52)	9,717	\$ 232,248		53

SEE ACCOUNTANTS' COMPILATION REPORT

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description		Amount		
Karolle Coppoc	Administrator	None	\$ 83,075	Workers' Compensation Insurance		\$ 44,394	IDPH License Fee		\$		
				Unemployment Compensation Insurance		8,563	Advertising: Employee Recruitment				
				FICA Taxes		107,945	Health Care Worker Background Check (Indicate # of checks performed _____)				
				Employee Health Insurance		32,939	Licenses and Permits		748		
				Employee Meals		479	Allocation of Management Fee		1,200		
				Illinois Municipal Retirement Fund (IMRF)*			Subscriptions		75		
				Life Insurance		339	Computer Fees		6,768		
				Dental Insurance		243	Membership Fees		5,564		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						13,038	Bank/Investment fees		13,662		
						(357)	Less: Public Relations Expense		(		
B. Administrative - Other						3,415	Non-allowable advertising		(		
						14,797	Yellow page advertising		(		
						(18,914)					
							TOTAL (agree to Sch. V, line 20, col. 8)		\$ 28,017		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 83,075					
B. Administrative - Other											
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 83,075					
B. Administrative - Other											
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 83,075					
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B. Administrative - Other											
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 83,075					
B. Administrative - Other											

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

(Continued from Page 1)													
1	2	3	4	5	6	7	8	9	10	11	12	13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Baptist Retirement Home

STATE OF ILLINOIS

# 0040584

Report Period Beginning:

9/1/00

Ending:

Page 23

8/31/01

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes LPN
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Life Services Network \$4358.95
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 8
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \$22,623/\$7334 Line 10.3
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 41,063  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 479 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 186
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? Yes  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 50%  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? No  
Attach invoices and a summary of services for all architect and appraisal fees.